Step-by-Step Instructions for Completing
The CMS/HCFA 1500 Claim Form
For MaineCare Covered Services

Introduction

The CMS 1500 form, previously known as the HCFA 1500 form, is a billing form maintained by the National Uniform Billing Committee (NUBC). Each payer, including MaineCare, has different requirements for completing specific parts of the claim form.

You are responsible for obtaining your own CMS/HCFA 1500 forms; the Maine Department of Health and Human Services (DHHS) does not provide them.

CMS/HCFA 1500 forms are red printing on white paper. You can buy the forms at office supply centers and from other sources including:

> U.S. Government Printing Office
> Mail Stop: IDCC
> 732 N. Capitol St. NW
> Washington, DC 20401
> http://www.gpo.gov/

Who Must Use the CMS/HCFA 1500

If you are one of the following providers, you must use the CMS/HCFA 1500 form:

> Advance Practice Registered Nursing Services
>
> Ambulances
>
> Ambulatory Care Clinics
>
> Ambulatory Surgical Centers
>
> Audiologists
>
> Chiropractic Services
>
> Community Support Services
>
> Consumer Directed Attendant Services
>
> Day Habilitation Services for Persons with Mental Retardation

Day Health Services

Day Treatment Services

Developmental and Behavioral Clinics

Medical Supplies and Durable Medical Equipment

Early Intervention Services

Family Planning Clinics

Federally Qualified Health Centers

Genetic Testing and Clinical Genetic Services

Hearing Aids and Services

Home and Community Based Benefits for the Elderly and for Adults with Disabilities

Home and Community Based Benefits for Members with Mental Retardation

Home and Community Based Benefits for the Physically Disabled

Home Based Mental Health Services

Independent Laboratories

Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, and Licensed Marriage and Family Therapist Services

Medical Imaging Services

Occupational Therapy Services

Optometrists

Outpatient Mental Health Providers

Physical Therapy Services

Physician Services

Psychological Services
Podiatrist Services

Rehabilitation Services

Rural Health Clinic Services

School Based Rehabilitation Services

Speech and Hearing Services

Substance Abuse Treatment Services

Targeted Case Management Providers

Transportation/Wheelchair Van Services

VD Clinics

Vision Services

You May Need Special Instructions

Some providers who use the CMS/HCFA 1500 form need to follow special instructions for certain fields. If you are one of the providers listed below, look for *Special Instructions:* and the appropriate icon for you:

MH Mental Health Providers

QMB For a member who has Qualified Medicare Beneficiary (QMB) eligibility [note: MaineCare pays the cost of Medicare premiums, deductibles and coinsurances]

SA Substance Abuse Service Providers

TRANS/AMB Full Service Transportation/Wheelchair Van and Ambulance Providers

Also look for these icons:

Attach reminds you where you need to attach documentation for this claim.

➔ **Appendix** reminds you to check the Appendices for information such as billing for Medicare or other insurance.

Appendix A is on Page 40; Appendix B is on Page 44; and Appendix C is on Page 45.
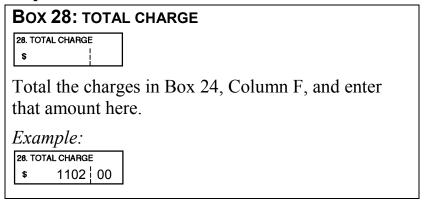
Required and Not Required Boxes and Fields

Boxes and fields that are not required are shaded. All required boxes are clear.

Not Required:

BOX 4: INSURED'S NAME

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

Not required.

Required:

BOX 28: TOTAL CHARGE

28. TOTAL CHARGE
$

Total the charges in Box 24, Column F, and enter that amount here.

Example:

28. TOTAL CHARGE
$ 1102 | 00

Please note, although some boxes are not required, they are not shaded. This is because DHHS recommends that you enter optional information in these boxes. This optional information, such as the patient's account number, will help you in your recordkeeping.

Examples and Additional Help

The instructions for each required box or field include an example of what the completed box or field should look like. In some boxes that have special instructions for certain providers, there are additional examples for those providers.

The instructions also give you important information and help.

Look for these icons:

ALERT: Required Action

TIP: Helpful Hint

Additional Tips on Filing

Here's other important information you need to know before you begin filling out your form:

- Use current CPT (Current Procedural Terminology) of the American Medical Association, ICD 9 (International Classification of Diseases) Diagnostic Codes, or HCPCS (Healthcare Common Procedure Coding System) Codes maintained by the Centers for Medicare and Medicaid Services. Or,

- Use the Procedure Codes in Chapter III of the *MaineCare Benefits Manual* policy section under which you bill. You may access these codes at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm

- The required format for a birth date is MMDDYYYY. (Example: January 19, 1947 = 01191947.)

- Whether you fill in your claim form by typing, computer, or handwriting, keep all information within the designated boxes. Do not overlap information into other fields. If the information is not in the required fields your claims will be returned to you with a cover letter stating that the information is not aligned correctly.

Mailing Your Claim

If you are a Transportation provider, mail your completed claim form to this address:

> MaineCare Claims Processing
> M-1400
> Augusta, ME 04333

All other providers, mail your completed claim form to this address:

> MaineCare Claims Processing
> M-500
> Augusta, ME 04332

You may also bill electronically through Electronic Media Claims (EMC) batch billing. Contact the Provider File Unit at 1-800-321-5557, Option 6 (In State only) or 207-287-4082 for more information on electronic billing. You can find additional information on the website for the Office of MaineCare Services (OMS) at: http://www.maine.gov/dhhs/emc/index.htm

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The following are the step-by-step instructions for completing each box or field in the CMS/HCFA 1500 form.

Instructions for All Boxes and Fields on

The CMS/HCFA 1500 Claim Form

Box 1

Box 1:

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☐ (ID)

Enter an X in the first box for Medicare when billing for Medicare coinsurance or deductible if you are one of the following providers:

> Ambulance
> Ambulatory Care Clinic
> Indian Health Center
> Advanced Nurse Practitioner
> Mental Health Clinic
> Optometrist
> Physician
> Podiatrist
> Psychologist
> QMB/"Quimby" Provider (See Alert)
> Federally Qualified Health Center
> Rural Health Center

Note: This box replaces box 24J (COB) on the old form.

Example:

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☒ (Medicare #)	☐ (Medicaid #)	☐ (Sponsor's SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☐ (ID)

📣 **ALERT:**

See **Appendix A, Page 41**, for billing coinsurance and deductible.

📣 **ALERT:**

If a member has Qualified Medicare Beneficiary (QMB) eligibility only and Medicare has approved the service, follow the instructions in Appendix A for billing Medicare coinsurance and deductible. If Medicare has not approved the service, no reimbursement is available.

BOX 1a: INSURED'S I.D. NUMBER

1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)

Enter the member's MaineCare ID number exactly as shown on the member's MaineCare ID card.

Example:

1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
12121212A	

☞ **TIP:**

You must verify the member's eligibility status. Use the swipe card system or the Interactive Voice Response (IVR) system at 1-800-452-4694 (In State Only) or 207-287-3081 (In State or Out of State.

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BOX 2: PATIENT'S NAME

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Enter the member's last name, first name and middle initial (if any) **exactly** as shown on his/her MaineCare ID card.

*Example: Member's name is Belle St. Pierre, the MaineCare Card reads St Pierre, Belle with no punctuation**, replace the period with a space as shown on the MaineCare Card.***
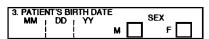
Example:

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
    St Pierre, Belle

🔊 **ALERT:**

Enter the member's name **exactly** as shown on the MaineCare ID card. If the name does not match, the claim will deny for incorrect name.
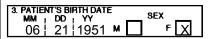
BOX 3: PATIENT'S BIRTH DATE AND SEX

3. PATIENT'S BIRTH DATE
MM | DD | YY   SEX
                M ☐   F ☐

Enter the month, day and year the member was born. The format for a birth date **must** be MMDDYYYY.

Enter an X in the appropriate M or F checkbox for the member's sex.

Example:

3. PATIENT'S BIRTH DATE
MM | DD | YY   SEX
06 | 21 | 1951 M ☐   F ☒

☞ **TIP:**

Throughout this form, please enter information within the boundaries of each box or field. Do not overlap into other boxes or fields.

BOX 4: INSURED'S NAME

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

Not required.

BOX 5: PATIENT'S ADDRESS

5. PATIENT'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)
(   )

Not required.

BOX 6: PATIENT RELATIONSHIP TO INSURED

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

Not required.

BOX 7: INSURED'S ADDRESS

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)
(   )

Not required.

BOX 8: PATIENT STATUS

8. PATIENT STATUS
Single ☐   Married ☐   Other ☐

Employed ☐   Full-Time Student ☐   Part-Time Student ☐

Not required.

Box 9

BOX 9: OTHER INSURED'S NAME

```
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)


a. OTHER INSURED'S POLICY OR GROUP NUMBER


b. OTHER INSURED'S DATE OF BIRTH          SEX
    MM    DD    YY                    M □      F □
c. EMPLOYER'S NAME OR SCHOOL NAME


d. INSURANCE PLAN NAME OR PROGRAM NAME
```
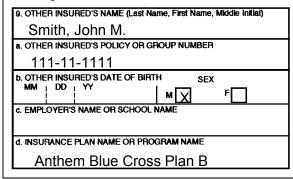
If the member is covered by a primary insurance other than MaineCare or Medicare, enter the name of the policyholder. Do not enter Medicare or any other State program information. If you complete this box, also complete Boxes 9a and 9d. Instructions for Boxes 9a and 9d are on the next page.

If there is no other insurance, leave this box and all fields (9–9d) blank.

Example:

```
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
    Smith, John M.
a. OTHER INSURED'S POLICY OR GROUP NUMBER
    111-11-1111
b. OTHER INSURED'S DATE OF BIRTH          SEX
    MM    DD    YY                    M ☒      F □
c. EMPLOYER'S NAME OR SCHOOL NAME


d. INSURANCE PLAN NAME OR PROGRAM NAME
    Anthem Blue Cross Plan B
```

📢 **ALERT:**

You must submit the claim to other insurers prior to submitting the claim to MaineCare.

📑**Attach a copy of the Explanation of Benefits or Remittance Statement from the primary insurance.**

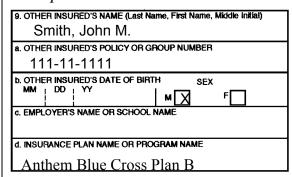**BOX 9a: OTHER INSURED'S POLICY OR GROUP NUMBER**

Enter the policy or group number of the primary insurance.

BOX 9d: INSURANCE PLAN NAME OR PROGRAM NAME

Enter the name of the primary insurance plan or program name. (Example: Anthem Blue Cross Plan B.)

When billing for Medicare C (Medicare Advantage Plans), list "Medicare Replacement" here.

Example:

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
Smith, John M.

a. OTHER INSURED'S POLICY OR GROUP NUMBER
111-11-1111

b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M [X] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
Anthem Blue Cross Plan B

📢 **ALERT:**

You must submit the claim to other insurers prior to submitting the claim to MaineCare.

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BOX 10: IS PATIENT'S CONDITION RELATED TO:

```
10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)
           [ ] YES      [ ] NO
b. AUTO ACCIDENT?              PLACE (State)
           [ ] YES      [ ] NO    |___|
c. OTHER ACCIDENT?
           [ ] YES      [ ] NO
```

If applicable, enter an X in each appropriate checkbox
(a, b, and c). If a, b, and c are not applicable, you may leave
those checkboxes blank.

BOX 10a: EMPLOYMENT? (CURRENT OR PREVIOUS)

BOX 10b: AUTO ACCIDENT? / PLACE (STATE)

BOX 10c: OTHER ACCIDENT

Example:

```
10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)
           [ ] YES      [X] NO
b. AUTO ACCIDENT?              PLACE (State)
           [X] YES     [ ] NO   |PA |
c. OTHER ACCIDENT?
           [ ] YES      [X] NO
```

BOX 10d: RESERVED FOR LOCAL USE

```
10d. RESERVED FOR LOCAL USE

```

Not Required

CMS 1500 (New Form) Billing Instructions
Revised 08/25/2009

BOX 11: INSURED'S POLICY GROUP OR FECA NUMBER

```
11. INSURED'S POLICY GROUP OR FECA NUMBER


a. INSURED'S DATE OF BIRTH                     SEX
   MM   DD   YY
                          M [  ]      F [  ]
b. EMPLOYER'S NAME OR SCHOOL NAME


c. INSURANCE PLAN NAME OR PROGRAM NAME


d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
   [  ] YES    [  ] NO    If yes, return to and complete item 9 a-d.
```

📢 **ALERT:**

If the member has a secondary insurance other than MaineCare or Medicare these boxes must be completed.

If YES is checked in Box 11d, enter the policy or group number. **Do not enter Medicare or any State program.**

BOX 11a: INSURED'S DATE OF BIRTH AND SEX

If YES is checked in Box 11d, enter the month, day and year the policyholder was born. The format for a birth date must be MMDDYYYY.

Enter an X in the appropriate box for the policyholder's sex.

BOX 11b: EMPLOYER'S NAME OR SCHOOL NAME

If YES is checked in Box 11d, enter the name of the policyholder's employer or school.

BOX 11c: INSURANCE PLAN NAME OR PROGRAM NAME

If YES is checked in Box 11d, enter the name of the policyholder's insurance plan or program. Do not enter Medicare or the name of any State program.

BOX 11d: IS THERE ANOTHER HEALTH BENEFIT PLAN?

If the MaineCare member is covered by other primary insurance and he/she is not the policyholder, enter an X in the YES box and also complete Fields 9a–9c. Do not check the YES box if the member has Medicare or is covered by any other State program. If there is no other insurance, enter an X in the NO box.

Example:

```
11. INSURED'S POLICY GROUP OR FECA NUMBER
              41216
a. INSURED'S DATE OF BIRTH                     SEX
   MM   DD   YY
   06   16   1947        M [X]      F [  ]
b. EMPLOYER'S NAME OR SCHOOL NAME
        Acme Corporation
c. INSURANCE PLAN NAME OR PROGRAM NAME
        Anthem Blue Cross Plan B
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
   [X] YES    [  ] NO    If yes, return to and complete item 9 a-d.
```

BOX 12: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary
  to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment
  below.

SIGNED_____   DATE _____

Not required.

BOX 13: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
  payment of medical benefits to the undersigned physician or supplier for
  services described below.

SIGNED _____

Not required.

BOX 14: DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY

14. DATE OF CURRENT: ILLNESS (First symptom) OR
  MM   DD   YY   INJURY (Accident) OR
                        PREGNANCY(LMP)

Not required.

BOX 15: IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.
  GIVE FIRST DATE   MM   DD   YY

Not required.

BOX 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
          MM   DD   YY   MM   DD   YY
  FROM   TO

Not required.

CMS 1500 (New Form) Billing Instructions
Revised 08/25/2009

BOX 17 : NAME OF REFERRING PROVIDER OR OTHER SOURCE

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Not required.

BOX 17a & b: I.D. NUMBER OF REFERRING PHYSICIAN

 ALERT:

Enter the MaineCare Managed Care Referral Number only. All Managed Care referral numbers begin with 000.

17a		
17b	NPI	

Line a: If the member is enrolled in MaineCare Managed Care and the service requires a referral number from the Primary Care Provider (PCP) site, enter **1D** which is the 2 digit qualifier indicating that it is MaineCare managed care provider in the first box and the PCP's site-specific, nine-digit referral number in the box beside it.

Line b: Enter PCP's 10 digit NPI number if available, MaineCare does not require it at this time.

Example:

17a	1D	000123401
17b	NPI	

For additional information regarding MaineCare Managed Care, please use the following website:
http://www.maine.gov/dhhs/bms/providerfiles/provider_managed_care.htm

BOX 18: **HOSPITALIZATION DATES RELATED TO CURRENT
SERVICES**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
MM | DD | YY   MM | DD | YY
FROM   TO

Not required.

BOX 19: **RESERVED FOR LOCAL USE**

19. RESERVED FOR LOCAL USE

If you are billing a J code in Box 24D, enter the National
Drug Code (NDC) for that drug. Do not enter the description
of the drug, and do not enter NDC before the actual NDC
code. Only one J code may be billed per claim.

NDCs printed on packages often have fewer then 11 digits,
with hyphens (-) separating the number into three segments.
For a complete 11-digit number, the first segment must have 5
digits, the second segment must have 4 digits, and the third
segment must have 2 digits. Leading zeros are added left-
justified, wherever they are needed to complete a segment with
the correct number of digits.

Package Number	Zero Fill (5-4-2)	11-digit NDC
1234-1234-12	(01234-1234-12)	01234123412
12345-123-12	(12345-0123-12)	12345012312

19. RESERVED FOR LOCAL USE

📢 **ALERT:**

You can only bill
one J code on a
paper claim.

If you try to bill
an NDC code
electronically,
the system won't
read the code.

If there is an
appropriate J
code you must
use it instead of a
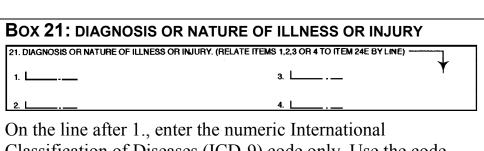9000 code. This
does not apply to
immunizations

**Do not include
hyphens** or alpha
characters in
block 19.

The rebate able NDC list is posted on the MaineCare services website
www.mainecarepdl.org/index.plhome/cms-rebateable-drugs
Provider Instructions for requesting In-state Physician Administered Non-Rebaeable J-Codes
Policy: Chapter II, Section 90.04-7 (http:www.main.gov/sos/ccc/rules/10/ch101.htm)
To request a prior authorization for this service, the Physician Administered Non-Rebateable J-
Codes form must be completed and submitted. The form can be found by visiting
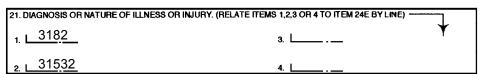http://www.maine.gov/dhhs/bms/provider files/pacriteriasheets.htm

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**Box
20 - 21**

BOX 20: OUTSIDE LAB?

20. OUTSIDE LAB?	$ CHARGES
☐ YES ☐ NO	

Not required.

BOX 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. |____.__   3. |____.__

2. |____.__   4. |____.__

On the line after 1., enter the numeric International Classification of Diseases (ICD-9) code only. Use the code that is as specific as possible, according to ICD-9 coding guidelines. Do not enter the description of the diagnostic code.

If there is more than one diagnosis, enter each code on the line after 2., 3., and 4. You may not enter more than four diagnoses.

Example:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. | 3182   3. |____.__

2. | 31532   4. |____.__

Special Instructions:

TRANS Full Service Transportation/Wheelchair Van Providers only: Not required.

🔊 **ALERT:**

As a Provider, you are expected to have up-to-date code books for diagnoses and procedure codes.

Do not use a decimal point in the diagnosis code.

BOX 22: MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.

ALERT:

To replace or void the entire claim enter the Original Ref. No. (TCN) that ends with zero.

If you do not replace or void the entire claim you can only replace one line per claim using the line TCN ending in 01, 02, 03, etc.

If this is an adjustment claim, in the Medicaid Resubmission Code field, enter one of the following:

7 – for **Replacement** of a previous claim

8 – for **Void** or **Cancel**

In the Original Ref. No. field, enter the previous Transaction Control Number (TCN) for the line you are adjusting.

Attach a copy of your original claim and remittance advice statement (RA) that shows the corresponding 18 digit TCN.

Example:

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7	002005045520029000

BOX 23: PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER

If applicable, enter the nine-digit Prior Authorization number issued by the authorizing unit for the services or supplies being billed on this form. You may bill only one Prior Authorization number on each claim form.

Example:

23. PRIOR AUTHORIZATION NUMBER
100112333

**Box
24**

BOX 24: (BOX HAS NO TITLE)

→ Appendix A: If you are allowed to bill for Medicare coinsurance and deductible (**you are a Provider listed in Box 1)**, see **Appendix A, Page 41**, for billing coinsurance and deductible.

→ Appendix B: If you are billing after Medicare and you **are not a Provider listed in Box 1**, see **Appendix B, Page 44**.

→ Appendix C: If you are **billing after commercial insurance**, see **Appendix C, Page 45**.

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From			To					CPT/HCPCS	MODIFIER						
MM	DD	YY	MM	DD	YY										
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	

For each line item billed, you must include one date, one place of service, one procedure code, and one amount charged per line. For a paper claim, you may not bill more than six lines.

See the following pages for instructions for Boxes 24A–24J.

◀)) **ALERT:**
Appendix A providers are required to check the Medicare block in **Box 1**.

The shaded area on each line is for supplemental information all information should be below the shaded area **except the Servicing Provider number in Column J must be in the shaded area** and the NPI number of the servicing provider on the line below the shaded area.

◀)) **ALERT:**

This claim is limited to six lines.

BOX 24A: DATE(S) OF SERVICE

Enter both "From" and "To" dates of service using either six-digit (MMDDYY) or eight-digit (MMDDYYYY) format. Do not use commas, dashes, or slashes in the date.

Dates must be consecutive and continuous. If the service was provided on only one day, just put that date in the From field. On each line, the From and To dates must be during one month. Use the next line for the next month.

Example:

24.	A				
	DATE(S) OF SERVICE				
	From			To	
MM	DD	YY	MM	DD	YY
09	01	2007			
09	02	2007	09	08	2007
09	09	2007	09	15	2007
09	16	2007	09	22	2007
09	23	2007	09	29	2007
09	30	2007			

◀))) ALERT:

You can call 1-800-321-5557 to check the member's eligibility.

◀))) ALERT:

BMR Waiver procedure code W125 must bill in a calendar week format (Sunday to Saturday). The only exception is in months that the first day of the month is a Saturday or the last day of the month is a Sunday. The example shows exactly how to bill that scenario.

BOX 24B: PLACE OF SERVICE

Enter a two-digit Place of Service code from the following list:

01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic

(Code list continued on the next page.)

ALERT:

Hospital based primary care physicians billing outpatient services: Use place of service **code 11**

Early Intervention Programs: Use Place of Service **code 99**.

Full Service Transportation/ Wheelchair Van Providers: Use the Place of Service code you transported the member to.

Durable Medical Equipment and Supplies Providers: Use the Place of Service code where the member resides.

Medical Imaging Mobile Unit use Place of Service **Code 15**.

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(Place of Service codes continued)

    50   Federally Qualified Health Center

    51   Inpatient Psychiatric Facility

    52   Psychiatric Facility – Partial Hospitalization

    53   Community Mental Health Center

    54   ICF/MR

    55   Residential Substance Abuse Treatment Facility

    56   Psychiatric Residential Treatment Facility

    57   Non-Resident Substance Abuse Treatment Facility

    61   Comprehensive Inpatient Rehabilitation Center

    62   Comprehensive Outpatient Rehabilitation Center

    65   End Stage Renal Disease Treatment Facility

    71   State or Local Public Health Clinic

    72   Rural Health Center

    81   Independent Laboratory

    99   Other

Example:

B
Place of Service
11

BOX 24C: EMG

Enter a Y to prevent copay from being deducted if you are not billing services that are exempt from copay.

Refer to Chapter I of the *MaineCare Benefits Manual* for a list of services exempt from copays.

Example:

I
EMG
Y

) TIP:

This box replaces the EMR diagnosis code previously used to bypass copay according to Chapter I.

BOX 24D: PROCEDURES, SERVICES OR SUPPLIES

Enter the appropriate procedure code and modifier(s), if necessary **in the unshaded area**.. Procedure codes and modifiers are in Chapter III of the *MaineCare Benefits Manual* and on the Office of MaineCare Services website, http://www.state.me.us/bms/bmshome.htm

NOTE: The shaded area at the top of this box is to be used for supplemental information only.

Transportation Example: Physician Example:

D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
CPT/HCPCS	MODIFIER
T042	ED

D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		
CPT/HCPCS	MODIFIER	
38760	80	50

Ambulance Example:

D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		
CPT/HCPCS	MODIFIER	
A0428	H9	PH

(24 D Continued on next page

ALERT:

CRNAS (Certified Registered Nurse Anesthetist) billing for anesthesia must use the QZ modifier.

ASCS (Ambulatory Surgical Centers) must use an SG modifier with the CPT code.

TIP:

Be sure that all information is legible and in the proper block.

(24D continued.)

TRANS/AMB Full Service Transportation/Wheelchair Van and Ambulance Providers:

In the Modifier field, enter the appropriate two letters for the transport's place of origin and destination from the following list (as shown in the example above):

D. Diagnostic or therapeutic site other than P or H.

E. Residential domiciliary, custodial facility (nursing home, not skilled nursing facility)

G. Hospital-based dialysis facility (hospital or hospital-related)

H. Hospital

I. Site transfer (e.g., airport or helicopter pad) between modes of ambulance transport

J. Non-hospital-based dialysis facility

N. Skilled nursing facility (SNF)

P. Physician's office (includes HMO non-hospital facility, clinic, etc.)

R. Residence

S. Scene of accident or acute event

X. (Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMP non-hospital facility, clinic, etc.

QL. Patient pronounced dead after ambulance called

UC. Unclassified ambulance service

Use of Modifier U1: Please see instructions for Box 24J.

BOX 24E: DIAGNOSIS POINTER

From Box 21, enter the line number or numbers (1, 2, 3, and/or 4) that list the diagnosis codes. Do not enter the codes themselves. List only the line numbers.

Example:

E
DIAGNOSIS CODE
1
1,3
2,3
1,2,3
2,4
1,2,3,4

Special Instructions:

TRANS Full Service Transportation/Wheelchair Van Providers only: Not required.

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BOX 24F: $ CHARGES

Enter the usual charge for the service you provided based on the policy section under which you are billing.

For more information on charges, see the MaineCare Benefits Manual (http://www.maine.gov/sos/cec/rules/10/ch101.htm).

➔ Appendix A: If you are allowed to bill for Medicare coinsurance and deductible see Appendix A, Page 40.

QMB If a member has Qualified Medicare Beneficiary (QMB) eligibility only and Medicare has approved the service, follow the instructions in Appendix A for billing Medicare coinsurance and deductible. If Medicare has not approved the service, no reimbursement is available.

➔ Appendix B: If you are not listed in Appendix A and you are billing after Medicare, see Appendix B, Page 44.

➔ Appendix C: If you are billing after commercial insurance, see Appendix C, Page 45.

If you are submitting for services that have been prior authorized, you must enter the lower of your usual and customary charges, or enter the prior authorized amount.

Example:

F
$ CHARGES
55 ¦ 00

☞ **TIP:**

Do not put a $ sign before the total. The $ can be picked up as an 8.

☞ **TIP:**

You should bill the total charges for all units in 24 G.

☞ **TIP:**

For billing Medicare non-covered charges refer to Appendix A and B

BOX 24G: DAYS OR UNITS

Enter the number of days of service or the units of supplies provided. Do not use decimal points or fractions. Round off to the nearest whole number. Enter 1 only if 1 unit was provided. (For example: For Indian Health Centers or Rural Health Centers, 1 unit of a visit is 1, not the units of itemized services provided in that visit.)

To find the definition of a unit, refer to the code descriptions or maximum allowance column in Chapter III of the *MaineCare Benefits Manual*, or refer to the CPT and HCPCS standard code listings.

Example:

G DAYS OR UNITS
1

ALERT:

Do not leave this field blank. Units must be whole numbers **do not use ¼, ½, ¾, etc.**

28

BOX 24H: EPSDT FAMILY PLAN

H
EPSDT Family Plan

Please check this box if applicable.

24I: ID QUALIFIER

Example:

ALERT:

You must enter the appropriate qualifier in the **shaded area** of this box

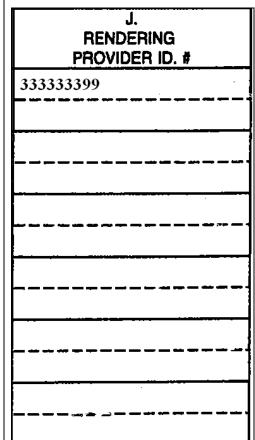1D indicates MaineCare Servicing Provider Number should be in Box J.

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24J: RENDERING PROVIDER ID NUMBER

Enter the Servicing Provider ID number in the shaded area, if applicable.

Enter the Servicing Provider NPI number in the area that is not shaded. MaineCare does not require an NPI at this time.

If a Servicing Provider ID number is not required, leave this field empty.

Example:

```
        J.
     RENDERING
   PROVIDER ID. #
333333399
```

☞ **TIP:**

Refer to your MaineCare enrollment letter for your Servicing Provider ID number or numbers.

🔊 **ALERT:**

The **Servicing Provider ID** number **always ends in 99.**

See Special Instructions for Box 24J on the next page, including a list of provider types that are not required to enter a Servicing Provider ID number.

31

Special Instructions for Box 24J	☞ **TIP:**
If you are one of the following providers or services, a Servicing Provider ID number is not required in Field 24J:	Refer to your MaineCare enrollment letter for your Servicing Provider ID number or numbers.

Special Instructions for Box 24J

If you are one of the following providers or services, a Servicing Provider ID number is not required in Field 24J:

> Ambulance
>
> Ambulatory Surgical Center
>
> BMR Waiver Provider – Section 21
>
> Case Management Provider – Section 17
>
> Community Support Services
> > CBB10
> > CBB17
>
> Consumer Directed Attendant Service – Section 12
>
> Day Habilitation Provider – Free Standing Day Habilitation billing under Section 24
>
> Day Health – Section 26
>
> Day Treatment Services Provider
>
> Developmental/Behavioral Clinic Provider – Section 23
>
> Durable Medical Equipment and Supplies Provider
>
> Early Intervention Program
>
> Full Service Transportation/Wheelchair Van Services
>
> Genetic Testing and Clinical Genetic Services – Section 62
>
> Home Based Mental Health Provider – Section 37
>
> Laboratory Services – Section 55
>
> Medical Imaging – Section 101

☞ **TIP:**

Refer to your MaineCare enrollment letter for your Servicing Provider ID number or numbers.

📢 **ALERT:**

The **Servicing Provider ID** number **always ends in 99.**

If a Servicing Provider ID number is not required, leave this field empty.

(List continued on the next page.)

(Special Instructions for Box 24J, continued.)
 	
(Provider types that are <u>not</u> required to enter a Servicing Provider ID number in Box 24J.)
 	
        <u>Any Provider Billing Social Services Codes</u>
          SS01   SS02 SS03 SS04
 	
Optical Contractor
 	
Rehabilitation Services Provider – Section 102
 	
School Based Rehabilitation Provider
 	
Substance Abuse Service Provider (For the following procedure codes, Field 24J must be left blank):
     H0015 Intensive Outpatient Services
     H0020 Methadone Clinic Services
VD Screening Clinic Services – Section 150
	📢 **ALERT:**
	
	The **Servicing Provider ID** number always **ends in 99.**
	
	☞ **TIP:**
	
	If you have questions call 1-800-321-5557 or 207-287-3081.
	
	.

<div align="right">

Box 25

</div>

BOX 25: FEDERAL TAX I.D. NUMBER | 25. FEDERAL TAX I.D. NUMBER	SSN EIN
---	---
	☐☐ | Although this is not required, DHHS highly recommends that you enter this information. If the Provider ID number in Box 33 is incorrect or missing, the claims unit uses the information in this box to inform you that your claim is denied. The SSN and EIN checkboxes are not required. *Example:* | 25. FEDERAL TAX I.D. NUMBER	SSN EIN
---	---
000000000	☐☐		☞ **TIP:** This is not your MaineCare Provider Number.

BOX 26: PATIENT'S ACCOUNT NO.

26. PATIENT'S ACCOUNT NO.

Although this box is not required, DHHS highly recommends including the patient's account number or the member's name here. If the MaineCare member's ID number in Box 1A is incorrect, the information you enter in this box will appear on your remittance statement. You will then be able to cross-reference the RA and your records.

If you are using a patient account number, enter the number (any alphanumeric combination up to 12 characters). If you do not use a patient account number, enter the member's name.

Example:

26. PATIENT'S ACCOUNT NO.
12345

Or:

26. PATIENT'S ACCOUNT NO.
SmithJ1

BOX 27: ACCEPT ASSIGNMENT?

27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)
☐ YES   ☐ NO
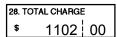
Not required.

Box
28

BOX 28: TOTAL CHARGE

28. TOTAL CHARGE	
$	

Total the charges in Box 24, Column F, and enter that amount here.

Example:

28. TOTAL CHARGE	
$	1102 : 00

ALERT:
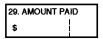
Each claim must be totaled. **Do not** write "continued on next page."

35

Box 29

BOX 29: **AMOUNT PAID**

29. AMOUNT PAID
$

➔ Appendix: See Appendices A, B, and C, Pages 40–43, for billing after Medicare or other commercial insurances.

📑**Attach** the third party Explanation of Benefits (EOB) for all claims involving a third party when balance billing MaineCare after you have received payment or denial from the primary health plan.

- If payment was made, you must enter the amount of the insurance payment in Box 29, as well as attach the third party Explanation of Benefits (EOB).

- In order for the claims payment system to properly distribute third party payments, only those line items paid by the third party can be billed on the same claim form.

- Those charges that have been denied by the insurer, where no third party payment was made, must be billed on a separate claim form, and you must include the third party Explanation of Benefits (EOB).

- Do not enter the Medicare payment in Box 29 if you are billing for Medicare coinsurance or deductible.

Spenddowns: Enter the total amount of payments from third party payers. If you have been issued a spenddown letter from the Office of Integrated Access and Support, enter the **patient responsibility** amount. The dates and amounts on this claim must match the spenddown letter.

📑**Attach** the spenddown letter to this claim.

Example:

29. AMOUNT PAID
$ 456 00

☞ **TIP:**

Do not enter the member's anticipated copay amount. It will be automatically deducted in the claims process.

📢 **ALERT:**

Be sure to attach a copy of the spenddown letter to each page of the claim.

BOX 30: BALANCE DUE
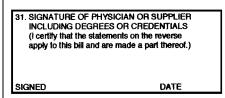
```
30. BALANCE DUE
$          ┊
```

Enter the balance due. Subtract the amount in Box 29 from the amount in Box 28. If Box 29 is greater than Box 28, enter 0. Do not enter negative numbers.

Example:

```
30. BALANCE DUE
$  1102 ┊ 00
```

**BOX 31: SIGNATURE OF PHYSICIAN OR SUPPLIER
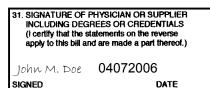INCLUDING DEGREES OR CREDENTIALS**

```
31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    INCLUDING DEGREES OR CREDENTIALS
    (I certify that the statements on the reverse
    apply to this bill and are made a part thereof.)


SIGNED                    DATE
```

Enter the Provider's name and billing date. The signature or name may be typed or stamped. The Provider's authorized person may sign. The name must be the name of an actual person.

Do not use "signature on file."

Degree or credentials are not required.

The format for the billing date is MMDDYYYY.

Example:

```
31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    INCLUDING DEGREES OR CREDENTIALS
    (I certify that the statements on the reverse
    apply to this bill and are made a part thereof.)

John M. Doe    04072006
SIGNED                    DATE
```
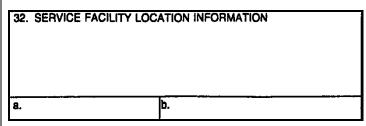
📢 **ALERT:**

The signed date must be the same date or a date later than the last date of service on this form.

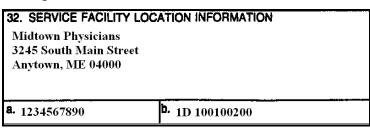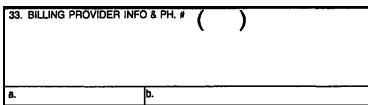Services may not be billed before they are provided.

Box 32

BOX 32: SERVICE FACILITILY LOCATION INFORMATION

```
32. SERVICE FACILITY LOCATION INFORMATION


a.                              b.
```

If services were in a location other than the Provider's office or the member's home, enter the name and address of that facility.

32 a. Enter the Facility NPI number. Not required at this time.

32 b. Enter the 2-digit MaineCare Identifier (1D) and one space followed by the Facility Provider number. Do not enter the Servicing Provider ID number here. Not required at this time.

Example:

```
32. SERVICE FACILITY LOCATION INFORMATION
  Midtown Physicians
  3245 South Main Street
  Anytown, ME 04000

a. 1234567890            b. 1D 100100200
```

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Box 33

BOX 33: BILLING PROVIDER INFO & PH.

```
33. BILLING PROVIDER INFO & PH. #    (       )



a.                        b.
```
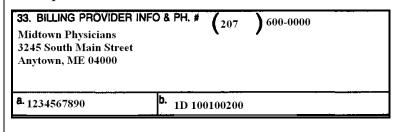
Enter the telephone number including area code.

Enter the Provider's name, address.

33 a. Enter the NPI number. Not required at this time.

33 b. Enter the 2-digit MaineCare Identifier (1D) and one space followed by the Provider ID number. Do not enter the Servicing Provider ID number here.

Example:

```
33. BILLING PROVIDER INFO & PH. #    ( 207 ) 600-0000
Midtown Physicians
3245 South Main Street
Anytown, ME 04000

a. 1234567890          b. 1D 100100200
```

◀))) **ALERT:**

Make sure your MaineCare Provider ID Number and qualifier are located in 33 b.

That number is used to pay your claim.

CMS 1500 (New Form) Billing Instructions
Revised 08/25/2009

<u>Appendix A</u>

Billing Medicare Coinsurance and/or Deductible to MaineCare

Providers who are listed to receive
coinsurance and deductible in full after Medicare

Important: You must bill any third party companion plans <u>prior</u> to billing MaineCare.

If you are one of the following Providers, you are allowed to bill for Medicare coinsurance and/or deductible:

> Ambulance
>
> Ambulatory Care Clinic
>
> Indian Health Center
>
> Advanced Nurse Practitioner
>
> Mental Health Clinic
>
> Optometrist
>
> Physician
>
> Podiatrist
>
> Psychologist
>
> Federally Qualified Health Center
>
> Rural Health Center
>
> QMB/"Quimby" <u>Provider</u>

If you are one of the above providers AND the member has only QMB benefits which are identified by their PINK sheet of paper. Billing instructions are the same. (QMB benefits pay the member's Medicare coinsurance and deductible only.) If you are NOT one of the above providers or the member has full MaineCare coverage, refer to Appendix B for billing instructions.

If you are an Ambulance, Ambulatory Care Clinic, Advanced Nurse Practitioner, Optometrist, Physician, Podiatrist, QMB/"Quimby" Provider, or Member is a Qualified Medicare Beneficiary (QMB) eligibility only complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

> Box 1: You must put an X in the Medicare box. This replaces the Y indicator used in 24 J on the old HCFA 1500.

> Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

> Box 24F: Charges must reflect the sum of the Medicare coinsurance and deductible amounts as shown on the Explanation of Medicare Benefits (EOMB).

> Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

> Box 29: Enter any other third party payment from an insurance company. Do not enter the Medicare payment.

> Box 30: Enter the balance due. This can not exceed the member responsibility shown on the Explanation of Benefits.

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any third party Explanation of Benefits (EOB).

Do not combine coinsurance / deductible charges with Medicare non-covered charges. Use one claim form for billing coinsurance / deductible charges and a separate claim for Medicare non-covered charges.

> Box 1: Do not put an X in the Medicare box.

> Box 24F: Charges must reflect your billed charges.

> Box 29: Enter any other third party payment from an insurance company.

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any third party Explanation of Benefits (EOB)

CMS 1500 (New Form) Billing Instructions
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If you are an Indian Health Center, a Federally Qualified Health Center, a Rural Health Center complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 1: You must put an X in the Medicare box. This replaces the Y idicator used in 24 J on the old HCFA 1500.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Charges must reflect your MaineCare rate of reimbursement minus the dollar amount paid by Medicare as indicated on the Explanation of Medicare Benefits (EOMB) attach the (EOMB).

Example: MaineCare rate is $100 per visit
Medicare paid $45 for the visit
Charges in 24F would be $55

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter any other third party payment from an insurance company. **Do not** enter the Medicare payment.

Box 30: Enter the balance due.

Do not combine coinsurance / deductible charges with Medicare non-covered charges. Use one claim form for billing coinsurance / deductible charges and a separate claim for Medicare non-covered charges.

Box 1: Do not put an X in the Medicare box.

Box 24F: Charges must reflect your billed charges.

Box 29: Enter any other third party payment from an insurance company.

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any third party Explanation of Benefits (EOB)

If you are a Federally Qualified Health Center Billing for a member that has Quimby only pink sheet of paper showing MaineCare coin/ded Coverage

Box 21: You are required to use a diagnostic code.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Charges must reflect your Medicare Coinsurance and Deductible as indicated on the Explanation of Medicare Benefits (EOMB).

Box 28: Total Coin Insurance from 24F

Box 29: Leave blank

Box 30: Total Coin Insurance from box 28

Example: Box 28 total coin insurance $20.00

Box 29 amount 0.00

Box 30 Total Due 20.00

If you are a Mental Health Clinic or Psychologist or Psychiatrist complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 1: You must put an X in the Medicare box. This replaces the Y indicator used in 24 J on the old HCFA 1500.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Charges must reflect your coinsurance and/or deductible and the amount of PR-122 as indicated on the Explanation of Medicare Benefits (EOMB).

Example: Coinsurance amount is $20 and PR-122 is $30
Charges in 24F would be $50

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter any other third party payment from an insurance company. **Do** not enter the Medicare payment.

Box 30: Enter the balance due.

Appendix B

Billing Medicare Coinsurance and Deductible to MaineCare

Providers who are **not** allowed to bill for coinsurance and deductible after Medicare

Important: You must bill any third party companion plans <u>prior</u> to billing MaineCare.

Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Enter the Medicare allowed amount as shown on the Explanation of Medicare Benefits (EOMB).

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter the sum of the Medicare payment and any other third party payment from an insurance company. **Note:** If the Medicare and/or other insurance payment exceeds the MaineCare rate there is no balance due.

Box 30: Enter the balance due. This can not exceed the member responsibility shown on the Explanation of Medicare Benefits (EOMB).

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any other third party Explanation of Benefits (EOB).

NOTE: If you are one of the proivders who bills Medicare and the member is QMB/ "Quimby" only, bill with the instructions listed above and use an X in Medicare Box 1.

Do not combine coinsurance / deductible charges with Medicare non-covered charges. Use one claim form for billing coinsurance / deductible charges and a separate claim for Medicare non-covered charges.

Box 24F: Charges must reflect your billed charges.

Box 29: Enter any other third party payment from an insurance company. Attach a copy of the Explanation of Medicare Benefits (EOMB) and any third party Explanation of Benefits (EOB)

Third Party Billing Instructions

1. Balance Billing Traditional Insurance Plans and Fee For Service
   Managed Care Plans

2. Physicians Billing Co pays for Capitated Services Under Managed Care   Plans

3. For balance billing traditional insurance plans and fee for service
   managed care plans

> Important: You must attach the third party Explanation of Benefits to the
> claim form.

> **Complete the CMS/HCFA 1500 claim form according to MaineCare**
> **requirements, along with the following:**

>> Box 24F: Charges must equal the allowed amount that you and the
>> insurance company agreed to, as shown on insurance company's
>> Explanation of Benefits (EOB).

>> Box 28: Enter the total charges. This must equal the total of the
>> individual line item charges in 24F.

>> Box 29: Enter the amount paid by insurance company/third party. The
>> third party amount must equal the actual third party payment, plus any
>> withheld amount shown on the insurance company's Explanation of
>> Benefits. You must enter this amount on the claim form, and you must
>> attach the Explanation of Benefits.

>> Box 30: Enter balance due. This can not exceed the member
>> responsibility shown on the Explanation of Benefits.

> Please remember, if the third party payment exceeds the MaineCare rate for
> the service, there is no balance due.

> Services not covered by the third party payer must be billed on a separate
> claim form with the Explanation of Benefits attached to the claim.

> You can not charge the patient the copay.

2. **For Physicians billing copays for capitated services under managed care plans:**

> NOTE: Capitated services are services covered under the monthly capitation payment agreement between a managed care plan and the member's provider.

> **Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:**

>> Box 24D: Enter the appropriate procedure code.

>> Box 24F: Charges must equal the copay amount.

>> Box 28: Enter the total copay charges. This must equal the total of the individual line item charges in 24F.

>> Box 29: Enter 0 (a zero).

>> Box 30: Enter amount from Box 28.

> Attach a copy of the Explanation of Benefits (EOB).

> You can only bill copays for capitated services under a managed care plan.

> Services not covered by the third party payer must be billed on a separate claim form with the Explanation of Benefits (EOB) attached to the claim.

> You can not charge the patient the copay.